

# **Evidence-Based Practice for Justice Involved Individuals**

## **Expert Panel Meeting**

### **Discussion Paper: Integrated Mental Health/Substance Abuse Responses to Justice Involved Persons with Co-Occurring Disorders**

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## Case Study

*Steve is a 28 year old African American male with a history of opiate dependence and cocaine abuse. He has been assessed as having a bipolar affective disorder with agitation and aggression associated with his hypomanic episodes and suicidal behavior associated with his depressed periods. He was convicted of child abuse (strangled his youngest son) and served two of his seven year felony sentence before release from prison. Prior to these charges he had multiple misdemeanor convictions for possession and sales. He was released from state prison 14 months ago and is currently on parole. He is highly motivated to end substance abuse patterns and believes a return to heroin "will kill me". On release, Steve was referred and participated in a dual disorder group, kept appointments with his psychiatrist, adhered to medication regimens, and remained abstinent. Steve has hepatitis C from past intravenous drug use and has consistently elevated liver enzymes. He is scheduled for a liver biopsy and may require hepatitis treatment.*

*Steve found a job as a short-order cook shortly after release and was able to earn enough money to both pay for a studio apartment and make child support payments. His job had health insurance. He left this job on good terms with a promise of employment at a higher paying job in the city. On background check, his felony conviction precluded him from getting the second job and his first employer already filled his position. Without income, he was evicted from his room after missing two rent payments, spent two weeks sleeping outdoors, and then managed to get access to a residential addiction program with no COD orientation.*

*Steve couldn't tolerate lithium (tremors), was stable on valproic acid but couldn't continue because of his liver status. Olanzapine was very helpful in stabilizing his mood, but without health insurance, he couldn't pay for it. Samples of quetiapine were provided but it made him too tired. He stopped all medications. He began to lose sleep and became irritable. He ran into old "friends" and smoked crack cocaine for 36 hours one week earlier. He stopped abusing crack on his own, but is very worried about his P.O. getting last week's urine toxicology results. He thinks he may be headed back to prison, or at best is headed for a severe depressive episode.*

Steve's story is typical of the complex needs of justice involved persons with COD. There is no simple evidence-based practice that will be responsive to his unique circumstances. The application and integration of multiple strategies is the challenge confronting consumers and providers.

## Introduction

There is an overrepresentation of persons with co-occurring disorders (COD) involved in the criminal justice system. The provision of integrated services to persons with COD has been identified as an evidence-based practice (EBP), and data suggests that positive public safety and health outcomes for justice involved persons with COD are associated with integrated program models as well. Sadly, in real world settings the vast majority of persons with COD, including those with histories of justice involvement, do not have access to integrated care. This paper will review the research associated with integrated treatment, highlight efforts to adapt integrated treatment for justice involved persons with COD, and describe efforts along a justice continuum to identify and link these persons to integrated treatment.

## Background of Justice Involved Persons with COD

The prevalence of high rates of co-occurring mental and substance related disorders within the general population has been well documented (Kessler, 2004; Substance Abuse and Mental Health Services administration [SAMHSA], 2004). Even the highest estimates of co-occurring disorders by condition in the general population are small compared to best data about COD prevalence in jails and prisons. With about 8% of the jail population having a serious mental illness (SMI), Abram and Teplin (1991) found that 72% of both male and female jail detainees with SMI had co-occurring substance use disorders. Almost 60% of offenders with mental illnesses incarcerated in prisons and jails report that they were under the influence of drugs or alcohol at the time of their offense (Ditton, 1999). This association appears to be true across diagnostic categories and is higher than inmates without mental illnesses. In one study, almost one-quarter of veterans with co-occurring disorders released from in-patient facilities were incarcerated within twelve months of discharge (Rosenheck, Banks, Pandiane, & Hoff, 2000) and rates of incarceration are generally higher for persons with COD compared with those with only mental illness (Mueser, Essock, Drake, Wolfe, & Frisman, 2001). There is some evidence that the absolute number and percentage of persons with co-occurring disorders in custody continues to grow (Sacks, Sacks, McKendrick, Banks, & Stommel, 2004).

The factors that contribute to this overrepresentation of COD in justice involved persons include:

- the high rates of substance use, abuse, and dependence among persons with mental illnesses (Grant et al., 2004; Regier et al., 1993) coupled with increased enforcement of illegal drug use, possession, and/or sales statutes leading to arrest;
- the association of COD and homelessness (Drake, Osher, & Wallach, 1991), and homelessness and incarceration (Michaels, Zoloth, Alcabes, Braslow, & Safyer, 1992) that brings a subset of impoverished persons with COD in contact with the justice system who often become “revolving door” clients;
- the increased application of mandatory minimum sentencing guidelines resulting in longer jail and prison periods of incarceration; and,

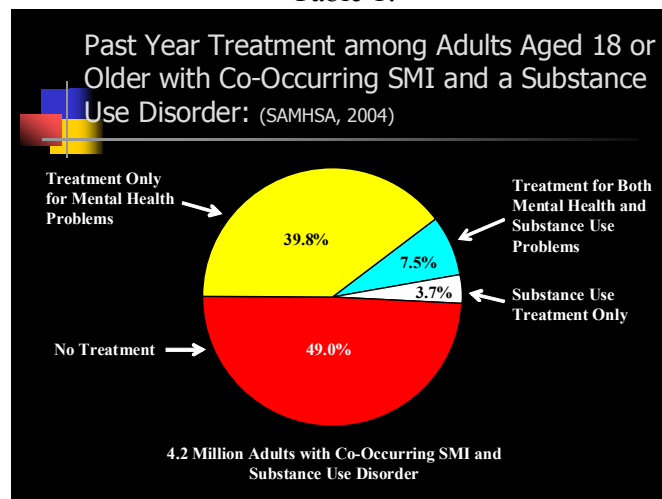
- the destabilizing effects of two sets of disorders and the resultant impaired cognitive and behavioral functioning that leads to both the commission of crimes and the inability to avoid arrest and subsequent sentencing.

In persons without mental illnesses, the use of drugs and alcohol has multiple negative consequences including interpersonal difficulties (arguments, fights, and violence), interference with work or school performance, and impaired health. In persons with mental illnesses, the effects of drugs and alcohol on these dimensions are exaggerated. Substance abuse is an associated factor in many crimes of violence and substance use disorders have been shown to significantly raise the rates of violence in persons with mental illnesses (Steadman et al., 1998).

### History of COD Treatment

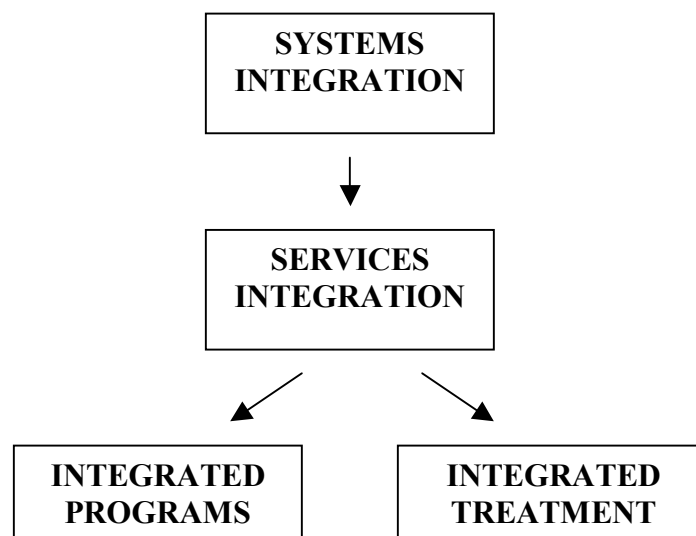
The history of treatment approaches to persons with COD reflects the division of mental health and substance abuse treatment systems. Separate regulations, financing, provider education and credentialing, and eligibility for services have existed for decades. The separation of service delivery mirrors the separation of policymaking and funding. As a result, persons with COD are refused service and shuffled between providers, and seldom receive comprehensive screening and assessment, let alone an effective package of services. Compounding these administrative barriers, the stigma, shame, and discrimination experienced by some consumers can prevent them from seeking care and inappropriately raises doubts about their competence to make decisions on their own behalf. These factors are reflected in the National Survey on Drug Use and Health finding that almost one-half of persons with COD received neither mental health nor substance abuse services in the year preceding the survey (see Table 1 of SAMHSA, 2004, for complete data). For those that do get service, the majority do not receive integrated care, but rather receive treatment within sequential and parallel treatment models (Mueser, Noordsy, Drake, & Fox, 2003; Watkins, Burnam, Kung, & Paddock, 2001) that appear to have little positive effect on outcomes (Drake, Mueser, Clark, & Wallach, 1996; Havassy, Shopshire, & Quigley, 2000).

Table 1:



Organizational features (financial, political, etc.) can facilitate or obstruct the adoption of evidence into practice (McLellan & Meyers, 2004; Rosenheck, 2001). In response to an awareness that traditional services (including no service) result in poor outcomes for persons with COD, mental health and substance abuse systems have been encouraged to collaborate. Programs emphasizing integration were developed and a new generation of providers was trained with the aim of integrating mental and substance abuse treatments. *Systems integration* is the process by which individual systems or collaborating systems organize themselves to implement services integration to clients and families with COD. Applying integrated COD models to justice involved persons necessitates the coordination with another system (criminal justice) and set of providers.

Table 2:



*Services integration* involves the participation of providers trained in both substance abuse and mental health services who develop a single treatment plan to address both sets of conditions and their continued formal interaction and cooperation to reassess and treat the client (Center for Substance Abuse Treatment [CSAT], 2005a). Services integration can be subdivided into integrated programs and integrated treatment. *Integrated programs* consist of policies, procedures, and activities that occur between providers. The degree of program integration varies between program models. Viewing integration on a continuum allows for these models to co-exist, to be applied to specific and unique populations, and does not suggest the relative value of one approach over another. One typology for the continuum of program integration is an outgrowth of the National Association of State Mental Health Program Directors and National Association of State Alcohol and Drug Abuse Directors (NASMHPD/NASADAD) national dialogue on co-occurring disorders (NASMHPD/NASADAD, 1999). This typology defines points on the integration continuum - consultation, collaboration, and full integration (see Glossary) - and reflects that COD clients with different needs require different levels of integration to achieve recovery goals. A threshold criterion for an EBP at the program

level is the endorsement and adherence to COD principles by all participants. Implementation of these principles varies widely.

*Integrated treatment* occurs at the interface of providers and the persons with COD. Integrated treatment is the application of knowledge, skills, and techniques by providers to comprehensively address both mental health and substance abuse issues in persons with COD. Integrated treatment may be delivered by a single provider, or a team of providers, but the activities are distinguished from integrated programs in that they involve direct contact with the affected client. An axiom derived from all integration efforts, is that the closer integration occurs to the client, the more likely it is to have an effect on specific client outcomes. As such, systems integration can be an enabling condition, but is not likely a sufficient condition to achieve valued clinical and public safety outcomes. This suggests that integrated treatment is critical and attention must be paid to the knowledge, attitudes, skills, and techniques of front-line providers.

Within CSATs' Treatment Improvement Protocol for Co-Occurring Disorders (CSAT, 2005b), establishing a therapeutic alliance is described as the foundation for successful interventions for persons with COD. Likewise, Mueser and colleagues (2003) argue that "shared decision making" is the bedrock of all integrated treatments. Little research exists on the therapeutic alliance with persons with COD, and the development and measurement of this construct is beyond the scope of this review. However, cultural competence, trauma sensitivity, and legal conditions all have an effect on the quality of the relationship. A threshold criteria for an EBP at the treatment level is the commitment by all providers to overarching COD principles of care and the recognition of the primacy of the therapeutic alliance as the central underpinning of all treatment efforts. It is within this therapeutic alliance that core elements of integrated care are selected and woven into an individualized treatment plan.

Systems and services integration have the potential to overcome organizational boundaries, resolve philosophical differences between the mental health and substance abuse fields, eliminate the pitfalls of sequential and parallel models, and respond comprehensively to individuals with complex service needs. Integrated programs and/or treatments can take place in either mental health or substance abuse systems. However, each integration model serves target populations with unique clinical, demographic, and social characteristics, operates within different system structures, uses providers with different skills, and prioritizes different outcomes. These multiple dimensions result in a wide variety of program models. To create a common ground for these efforts, overarching principles of care have been identified.

### Principles of Care for Persons with COD

Principles of care can provide a foundation for planning, delivering, financing, and evaluating treatment interventions. Several consensus processes have converged on the following principles to guide program and provider responses to people with COD (CSAT, 2005c).

- Co-occurring disorders must be expected and clinical services should incorporate this assumption in all screening, assessment and treatment planning
- Within the treatment context, both co-occurring disorders are considered primary
- Empathy, respect, and the belief in the individual's capacity for recovery are fundamental provider attitudes
- Treatment should be individualized to accommodate the specific needs and personal goals of unique individuals in different stages of change
- The contribution of community to the course of recovery for consumers with COD and the contributions of consumers with COD to the community must be explicitly recognized in program policy, treatment planning, and consumer advocacy

These principles should be equally applicable to the non-justice and justice involved persons with COD.

### Research Supporting Services Integration for COD as an EBP

As previously mentioned, services integration occurs at two distinct levels – integrated programs and integrated treatment. Critical components of services integration have been identified (CSAT, 2005b; Drake et al., 2001; Mueser et al., 2003). These consist of both programmatic elements (e.g. multi-disciplinary teams) and treatment elements (e.g. medications), each of which may have its own body of research evidence to support its effectiveness for specific populations to achieve specific outcomes. It is not the use of these components that makes a program integrated, but rather the coordination of appropriate components within a single program that determines the degree of program integration. Likewise, it is not the use of specific treatment techniques that make a treatment integrated, but the selection and blending of these techniques by the provider and their delivery to the consumer that defines integration. Ideally, the providers of integrated treatment would have access to all relevant mental health and all relevant substance abuse interventions to blend in an individualized treatment plan.

At the treatment level, interventions that have their own evidence to support them as EBPs and are frequently a part of a comprehensive and integrated response to persons with COD include:

- Psychopharmacological Interventions – Research has identified specific pharmacologic treatments for specific pairs of co-occurring conditions. For example, several quasi-experimental designed studies have suggested that clozapine can improve function and reduce substance abuse in persons with schizophrenia and substance use disorders (Noordsy & Green, 2003) and desipramine has been identified in randomized clinical trials as useful in the treatment of depression and cocaine abuse in persons with these disorders (Rounsaville, 2004).
- Motivational Interventions – the use of motivational enhancement therapy, an EBP within addictions treatment, has been applied to persons with COD (Carey,

Carey, Maisto, & Purnine, 2002) and demonstrated effectiveness in improving readiness for change.

- Cognitive-Behavioral Interventions – principles of cognitive behavioral therapy have been incorporated into active treatment and relapse prevention interventions in persons with serious mental illnesses and co-occurring substance use disorders (Mueser et al, 2003).

Also, integrated treatments with evidence derived from studies without rigorous methodology (not implying relative value), meeting evidence-based criteria at the level of emerging or promising practices (see Glossary), have been identified as important interventions to achieve desired outcomes for some populations with COD. Many of these interventions have an evidence base within singly diagnosed populations, but not in persons with COD. These include:

- Trauma-informed interventions
- Culturally competent treatment
- Mutual self-help groups
- Integrated screening and assessment
- Staged treatment interventions
- Dialectical behavioral therapy

At the program level, the following models have their own evidence-base for producing positive clinical outcomes for persons with COD (SAMHSA, 2002):

- Integrated Dual Disorders Treatment
- Modified Therapeutic Communities
- Assertive Community Treatment
- Housing with Appropriate Supports
- Supported Employment

Numerous efforts to take one or more of these treatment and program interventions and apply them to persons with COD while adhering to overarching COD principles, have demonstrated positive outcomes. This has contributed to a rapid acceptance of services integration as an evidence-based practice. Studies of specific models with specific subpopulations have served to increase the belief that integrated services produce improved outcomes. For example, Charney, Paraherikis, and Gill (2001) found improvement in affective symptoms and substance use outcomes when using an integrated care model for persons with major affective disorder and co-occurring substance use disorders.

Drake and colleagues (1998, 2001, 2004) reviewed 36 studies on the effectiveness of integrated treatment for persons with SMI and co-occurring substance use disorders. Eight of these studies had quasi-experimental designs with random assignment. In general, rates of stable remission of substance abuse were higher; rates of substance use in general were lower and some support for reduced arrests was found in the integrated programs. The authors concluded that integrated treatment, when delivered over a

sufficient length of time (18 months was proposed) to persons with serious mental illnesses, result in significant reductions of substance use and improvement in a range of other outcomes. Further examination of the common components of these effective programs led to the development of the Integrated Dual Disorders Treatment (IDDT) model for persons with serious mental illnesses and co-occurring substance use disorders (SAMHSA, 2003).

Not all reviews on integrated treatment have concluded that integrated treatment has risen to the threshold of an EBP (Donald, Dower, & Kavanagh, 2005; Jeffery, Ley, McLaren, & Siegfried, 2000). The Cochrane Collaboration concluded “the current momentum for integrated programmes is not based on good evidence. Implementation of new specialist substance misuse services for those with serious mental illnesses should be within the context of simple, well designed controlled clinical trials” (Jeffery et al, 2000). Critiques of this pessimistic interpretation of integrated treatment cite the need to separate poorly conceptualized and implemented older integration efforts from more recent approaches with sounder methodologies (Drake et al, 2001).

Cost effectiveness of specific service integration interventions has been studied with some suggestion that service integration interventions produce cost savings (Clark et al, 1998; Jerrell, 1996), or can be cost neutral while obtaining improved outcomes (French, Sacks, De Leon, Staines, McKendrick, 1999). Others have noted a graduated effect on cost related to the comprehensiveness of the integrated program (Kraft, Rothbard, Hadley, McLelland, & Asch, 1997).

### *Research limitations*

The lack of specificity of integrated interventions is a serious barrier to interpreting research findings. Interventions differ across studies and between approaches to individual, group, family, medication, and residential treatments. Although many studied programs stated the provision of “integrated” approaches, manualized interventions are not commonplace. Attention to fidelity in the application of research models in real-world settings can have a significant impact on attaining expected outcomes (McHugo, Drake, Teague, & Xie, 1999). While subsets of persons with COD respond favorably to integrated services, those who don’t are frequently caught up in cycles of homelessness, hospitalization, and incarceration. Therefore an assumption that services integration is effective in justice involved persons requires careful research attention.

While research on the sub-population of persons with SMI and COD has produced sufficient evidence to endorse services integration as an EBP, the evidence on populations with less serious disorders has yet to reach that threshold. Data has generally supported the effectiveness of integration in these “non-serious” populations and as such these programmatic models are promising, but additional controlled research studies are required. It is also the case that the bulk of research has focused on programmatic and treatment interventions, and insufficient data exists on proposed system models. There is

also insufficient data on the cost-effectiveness of integrated strategies. This domain is of critical importance to policymakers as they juggle competing priorities.

### Research on the Applications of EBPs for COD to Justice Involved Persons

When speaking of justice involved persons, the programs and front-line providers of integrated services expand to include court and corrections personnel. The requirement to incorporate justice programs and staff to address justice involved persons with COD adds complexity and opportunity to service integration efforts. Integrated behavioral health and justice programs and treatment strategies have been posited as the key to continuity of care with improved clinical outcomes and reduced recidivism to jail and prison settings (CMHS, 1995). Indeed, the hypothesis underpinning this review of EBPs for justice involved persons with COD can be stated as:

Interventions (at the program or provider level) that reduce substance use (licit and illicit) and improve levels of functioning in persons with COD will reduce both the frequency of their involvement with the justice system and their time spent in justice settings or under correctional supervision.

This hypothesis implies that the outcomes of less criminal activity (specifically the use of illegal drugs and violent behavior), fewer numbers of persons with COD at all points in the justice system, and improved re-integration of offenders with COD into community settings can be achieved through the application of effective service interventions targeting substance use, risk factors for criminal activity, and disabling mental health symptoms.

### *The Unique Role of Coercion*

While coercion is a consideration in the application of all EBPs to justice involved persons, its role in COD services integration is critical. First, measurable public safety outcomes include abstinence from all substances of abuse, adherence to prescribed medications, and participation in mental health and substance abuse treatment groups. These objective conditions are often written into terms and conditions of release, and the failure to achieve these standards can be used as a justification for re-incarceration. Second, for a group of individuals that have not been in treatment, incarceration represents an opportunity to engage that person, mandate treatment interventions that can reduce high-risk behavior, optimize other treatment strategies (e.g. medication management) in a controlled setting, and closely monitor consumer behavior. For offenders with substance abuse disorders, legal coercion has been shown to improve retention in treatment (Miller & Flaherty, 2000) which for these individuals was associated with decreased recidivism. The effectiveness of these strategies for justice involved persons with COD is essentially unknown (Skeem, Encandela, & Loudon, 2003). Third, having proposed that the therapeutic alliance between providers and the justice involved person is at the core of integrated treatment strategies, the impact of coercion requires thoughtful assessment and management.

From the justice involved person's perspective, the perception of coercion may be more important than the extent that the coercion is applied (Monahan et al., 1995). Approaches to the effective use of coercive interventions within the context of integrated treatment have been proposed (CSAT, 2005b, Mueser et al, 2003). The appropriate application of these strategies by providers is one of the adaptations to COD integrated services required to work with justice involved persons. The Institute of Medicine suggests that when coercion is legally authorized, patient-centered care is still applicable and client decision-making should be maximized by involvement in the selection of treatments and providers (Institute of Medicine, 2006). Ultimately, the challenge for the client will be to move beyond coercion as the external motivating factor for change to other internal and voluntary motivations.

### *Unique Features of Justice Involved Persons*

In addition to the unique role of coercion in justice involved interventions, justice involved individuals with COD may have unique clinical issues that must be addressed within integrated responses. An "incarceration culture" has been described (Rotter et al, 2005) in which behaviors adaptive with jail and prison settings may conflict with the expectations of most treatment environments. The inmate who learned to not share information with correctional staff may be seen as resistant when asked to be open and disclosing in treatment settings. Rotter et al (2005) postulate that "as a result, providers often experience unwarranted concerns about safety and lose opportunities for early and empathic engagement."

Reintegration into community settings is also more difficult for justice involved persons with COD. Stigma and discrimination that characterize societal responses to persons with COD are amplified with the addition of criminal charges. Access to federal subsidized housing, food stamps, or temporary cash assistance may be restricted for persons convicted of a state or federal felony offense of possession, use, or sale of drugs. A lack of resources complicates child care, transportation, education, and employment.

With these legal and clinical issues in mind, several specific program models have been applied to justice involved persons with COD and are discussed below.

### *Modified Therapeutic Community*

The modified therapeutic community (MTC) is an integrated program with a specific focus on public safety outcomes for persons with COD (De Leon, 1993, Sacks et al, 1997). It is a derivative of the therapeutic community (TC) which has data with substance abusing populations showing the models' effectiveness in reducing drug use and criminality (Hubbard et al, 1997). The MTC adapts the principles of therapeutic communities to the needs of persons with COD by increasing flexibility, decreasing intensity, and increasing individualization of approaches. MTCs use the "community-as-method" as the basis for both its program and treatment integration. Interventions are grouped into four categories – community enhancement, therapeutic/educative, community clinical management, and vocational (CSAT, 2005c). Building on

documented improvements in both substance use and employment outcomes (De Leon, Sacks, Staines, & McKendrick, 2000), MTCs have been shown to significantly lower reincarceration rates for persons with COD compared with groups receiving non-integrated services (Sacks et al., 2004). This has been demonstrated in prison-based MTCs and even larger effect sizes have been reported in residential MTCs (De Leon et al., 2000).

Sacks and colleagues (2004) reported outcomes associated with MTCs in one of the only randomized clinical trials of justice involved persons with COD. Colorado prison inmates with COD were randomly assigned to either the MTC (N = 92) or usual mental health services (N = 93). On their release from prison, inmates in the MTC group were given the option to continue in a residential MTC (N = 46). Compared with the mental health only group, those that had any MTC showed significantly lower rates of reincarceration and the MTC plus residential MTC group showed significantly better rates of reincarceration and a reduction in criminal activity. The authors conclude that the “study provides initial evidence that combining prison and aftercare MTC treatment improves crime outcomes, which confirms the benefits that accrue from such integrated programs.”

This evidence-based practice is manualized and been adopted in community residence programs, substance abuse treatment programs, prisons, and general hospitals. Access to MTCs is limited by their low number nationwide. With the data to support it as an EBP for justice involved persons, participation by appropriately defined justice involved persons with COD should result in improved public safety and behavioral health outcomes.

#### *Integrated Dual Disorder Treatment (IDDT)*

The Integrated Dual Disorder Treatment model combines program components and treatment elements to assure that persons with COD receive combined treatment for substance abuse and mental illness from the same team of providers (SAMHSA, 2003). The core eligibility criteria for IDDT include the presence of a serious mental illness and co-occurring substance use disorder. Additional criteria may be used to narrow the intended recipients and adaptations to the model must be made based on these criteria. The model starts with principles of integrated care and describes essential components of IDDT, but acknowledges that IDDT programs will differ from each other. Critical features of all IDDTs have been identified as the capacity to conduct state-of-the-art assessments followed by combinations of individual, group, and family treatment modalities (Mueser et al., 2003). The programs are contextualized and requisite organizational factors are outlined. These factors, the availability of essential elements, and adherence to treatment principles are the basis for the fidelity scale used to assess program model adherence.

The COD outcomes for IDDT were previously discussed as part of the evidence for the effectiveness of integrated strategies. There is little data to inform the discussion on the impact of IDDT on public safety outcomes for justice involved persons with COD. Secondary analysis of COD participants and their criminal justice involvement could shed some light on this question. If justice involved persons are targeted for IDDT services, modification of the model would likely need to take place to assure an adequate focus on the unique clinical and legal circumstances of this group in order to achieve optimal outcomes. These modifications occur *in vivo*, but await formal testing.

### *Assertive Community Treatment (ACT)*

The application of ACT, and its adaptations for justice involved persons (FACT, FICM) have been previously reviewed (Morrissey & Piper, 2005). As an EBP, ACT is a blend of program components and treatment elements. The model emerged in the early 70s as a response to persons with SMI leaving state institutions and has evolved, and been researched, with many sub-groups among persons with SMI. Notable was the models initial limited effectiveness for persons with co-occurring substance use disorders. This was addressed with the addition of several program elements reflected in the current fidelity measures (Teague, Bond, & Drake, 1998):

- a 100 client program should have at least two staff members with at least one year of training or clinical experience in substance abuse treatment;
- the ACT team should take full responsibility for all treatment services, including substance abuse treatment;
- one or more members of the program should provide direct individualized substance abuse treatment;
- the program should use dual disorder treatment groups for those clients with COD;
- the program should use a stage-wise treatment model that is non-confrontational, follows behavioral principles, considers interactions of mental illness and substance abuse; and has a gradual expectation of abstinence.

The significant impact of high fidelity ACT programs compared with low-fidelity ACT programs to achieve positive substance abuse outcomes for persons with COD (McHugo et al., 1999) is derived from the clear focus on substance abuse outcomes and the addition of these integrated program and treatment elements. The relatively weak data to support effectiveness of ACT for justice involved persons with COD (Morrissey & Piper, 2005) likely relates to a similar lack of focus on justice outcomes within traditional ACT models. Recent modifications to ACT leading to forensic assertive community treatment teams (FACT) and forensic intensive case management teams (FICM) seek to respond to desired public safety outcomes for persons with COD. Carefully designed randomized studies of these models have not yet occurred and as such, they remain promising practices.

## Applications of Integrated Mental Health/Substance Abuse Services for Justice Involved Persons with COD – The Sequential Intercept Model (Griffin, Wertheimer, & Munetz, 2004)

In applying service integration strategies for justice involved persons with COD it is necessary to look at both the program modifications that are required within the various settings of contact with the justice system and the unique aspects of linking justice involved persons from a point of contact to community providers. At the services level one can ask, what should/can happen uniquely at each point on the sequential intercept model to improve outcomes for persons with COD? How can EBPs be incorporated into the response?

### *Police based responses*

The earliest point of contact with the justice system is typically at the point of arrest. Innovation in police responses has led to the development of numerous models (Reuland & Cheney, 2005) aimed at reducing the number of persons with mental illness going to jail, improving officer and civilian safety, and increasing the officers understanding of behavioral disorders. As a front-line “provider” law enforcement staff cannot be expected to differentiate between the impact of drugs and mental illness on presenting behaviors. However, improved knowledge and attitudes about COD can help their crisis intervention. Key to an expanded set of incarceration alternatives is linkage to community providers at crisis centers and emergency rooms. The willingness and capacity to serve persons with COD of these community providers will likely impact outcomes for persons with COD. However, there is no current data on whether COD services integration at the provider level impacts police-based response outcomes.

### *Court based responses*

A growing number of persons with co-occurring mental health and substance abuse disorders appear before the court. It is critical that court staff understands, identifies, and accommodates the court process to the unique features of defendants with co-occurring disorders. For the courts, further efforts are required to establish the relationship between these clinical disorders and the criminal charges. Did these conditions affect the defendants understanding of the crime? Did the conditions influence the commission of the crime? Do these conditions affect the defendant’s capacity to participate in their own defense? Specialty courts (e.g. drug courts, mental health courts) have evolved within the U.S. as a response to increasing numbers of special populations on the court docket. A frustration with the poor outcomes for defendants with COD in traditional court programs has been described (Denckla, 2001). Peters & Osher (2004) have suggested several “core” modifications to court-based services for participants with COD that address their unique needs including:

- Screening and assessment approaches that examine both mental health and substance abuse content;
- Court staff education regarding mental health and substance abuse disorders;

- Adding medication monitoring to drug testing;
- Flexible application of graduated sanctions to accommodate the effects of mental health disorders and other individual needs of program participants;
- Liaison with other community mental health and substance abuse treatment providers; and
- Court hearings and judicial monitoring approaches that provide a rapid response to potential crises and specific court-ordered requirements for mental health and substance abuse services.

At the treatment level, some courts do support providers offering clinical services. It is critical that these court-based providers be capable of delivering, or accessing integrated treatments. There has been no test of these proposed modifications and without data, programs implementing these strategies can be considered emerging practices.

#### *Jail and Prison based responses*

Jails and prisons are constitutionally obligated to provide general and mental health care (Cohen, 2003) in addition to meeting detainees' other needs. In fact, incarcerated individuals are the only U.S. citizens with legally protected access to health care. Jails may be the first opportunity for problem identification, treatment and community referral (Peters & Matthews, 2002). Nonetheless, jails are high volume, highly structured, high turnover institutions with little time to initiate more than basic screening and assessment of mental health and substance abuse issues with appropriately matched urgent care responses. Opportunities for brief motivational interventions exist, yet the capacity of understaffed jail providers and inmates to develop a strong therapeutic alliance is limited. Jail behavioral health services mirror the community programs with a typical separation between addiction and mental health care (Peters & Hills, 1997).

Prisons are state or federally operated facilities for inmates with far longer sentences (usually exceeding one year) and as such, presumably have more opportunities to develop integrated service programs. While the vast majority of prisons have substance abuse programs, only a small minority of prisoners with substance use disorders get access to any addiction treatment (CSAT, 2005b). The likelihood of access to integrated dual disorder programs is even smaller. Several states have implemented modified therapeutic communities within their prisons. Sacks and colleagues (2004) reported positive findings on male prison inmates that were randomly assigned to either modified therapeutic communities (MTC) or usual prison mental health services (see above). The Washington and Vermont Department of Corrections have implemented dual diagnosis programs for long stay inmates using combined psychoeducational and cognitive therapy group interventions delivered over several months. There is no outcome data related to these efforts to date.

### *Re-entry and Community Corrections responses*

The inadequacy of discharge or transition planning activities for inmates released from jail and prison have been well documented (Council of State Governments, 2004; Osher, Steadman, & Barr, 2002; Steadman & Veysey, 1997). Clearly the identification of COD with the inmate population is a critical step to release planning and community linkage. For persons without conditions of release, access to integrated services will be at least as difficult as that of other citizens. For people with probation or parole terms, community supervision affords an opportunity to engage and monitor the person with COD in integrated settings. One unintended consequence of this close monitoring is that community corrections staff can be an increased detection of criminal activity (e.g. illicit drug use) and increased reincarceration rates (Taxman, 2002). Peters and Hills (1997) have outlined considerations for effective community supervision of offenders with COD, but no data from community efforts is available for review.

Given the chronicity and longitudinal nature of co-occurring disorders, the vast majority of integrated services for justice involved persons will occur within community settings. The success of law enforcement, courts, jails and prisons to identify persons with COD and link them to integrated care is posited to reduce the revolving door nature that characterizes their involvement with the justice system.

### Conclusions

Some services integration models have data to support their effectiveness as promising or evidence-based practices for justice involved persons with COD. But even with a dramatic increase in their diffusion to community practice, a relatively small percentage of justice involved persons will have access to them. It is important to provide incentives to address COD in justice systems. This can be achieved in part by documenting the high prevalence rates of COD within justice settings and the consequences, in terms of poor outcomes, for not providing optimal care. All justice settings should provide routine screening for CODs. Law enforcement, court, and corrections personnel should receive training and decision support in the application of effective EBPs to respond to the needs of persons with COD.

The majority of care is likely to be delivered in less structured programs and by clinicians who will hopefully embrace the principles of integrated care. Sustained attention should be paid to the development of a stronger workforce and specific clinical competencies should be identified. The Institute of Medicine (2006) proposes COD programs to be funded by the government and the private sector to address and resolve the shortage of well-trained providers and of programs for training competent clinician administrators.

There are many innovative behavioral and justice systems that strive to provide evidence-based integrated services to justice involved persons with COD. What remains is to implement strategies to expand access to effective responses so that a majority of

these vulnerable people might experience positive public safety and behavioral health outcomes.

<b>GLOSSARY OF TERMS</b>	
<b>Co-occurring Disorders (COD)</b>	COD refers to co-occurring substance-related and mental disorders. Clients said to have COD have one or more substance-related disorders as well as one or more mental disorders. COD exists when at least one disorder of each type can be established independent of the other and is not simply a cluster of symptoms resulting from a single disorder (CSAT, 2005b).
<b>Principle</b>	“A basic generalization that is accepted as true and that can be used as a basis for reasoning or conduct” (WordNet 2.0 2003 Princeton University). In the absence of evidence-based practices, principles serve to guide evidence based practice in the design of systems and service interventions. Principles are a product of a consensus process and can be referenced in practice recommendations.
<b>Evidence</b>	As applied to mental health and corrections, evidence is information that suggests a clearly identified outcome, for persons with mental illness involved in the criminal justice system is the result of a clearly identified practice or intervention. Evidence can be derived from different approaches yielding different degrees of certainty. The most reliable evidence comes from scientific research with rigorous design, using random assignment to control and experimental conditions, with large number of subjects, repeated multiple times, in multiple settings.
<b>Evidence-Based Thinking</b>	The conscientious, explicit, and judicious use of current best evidence in making decisions about the care of individual patients (Sackett, Rosenberg, Gray, Haynes, & Richardson, 1996).
<b>Promising Programs</b>	<p>As applied to MH-CJ, promising programs are those sets of clinical interventions or administrative practices that experts agree have some consistent empirical evidence, but lack the strongest scientific evidence (as outlined for evidence-based practices) that they produce desired outcomes.</p> <p style="text-align: center;">OR</p> <p>Promising programs are those clinical or administrative practices that have strong evidence of achieving mental health OR public safety outcomes, but not both. Promising practices may be elevated to the level of evidence-based practices with subsequent documentation of program effectiveness.</p>

<b>Emerging Programs</b>	As applied to MH-CJ, emerging programs are innovative clinical or administrative practices that address an important aspect of MH-CJ recovery/recidivism, that are endorsed by programs that can point to many cases of achieving desired outcomes, but lack the systematic data needed for empirical proof.
<b>Essential Program Components</b>	Essential program elements are discrete aspects of a program or provider interventions that are thought to be critical to the attainment of desired outcomes. Essential elements are identified through a consensus process that reviews program activity and distills key features. Essential elements can be operationalized and measured. The degree to which a program adheres or incorporates essential program elements is its practice fidelity.
<b>Treatment Elements</b>	Treatment elements are those techniques and strategies that are combined to advance the therapeutic alliance, improve motivation for change, and support the clients' fullest potential in recovery. The elements consist of EBPs (e.g. pharmacologic interventions, motivational interviewing, trauma interventions) and promising practices (e.g. consumer involvement), and emerging practices (e.g. culturally competent interventions).
<b>Screening for COD</b>	Determines the likelihood that a justice-involved person has co-occurring substance use and mental disorders or that his or her presenting signs, symptoms, or behaviors may be influenced by co-occurring issues. The purpose of screening is not to establish that COD is present, but to establish the need for an in-depth assessment (CSAT, 2005d).
<b>Assessment for COD</b>	Gathers information and engages in a process with the client that establishes the presence or absence of a co-occurring disorder, determines the client's readiness for change, identifies client strengths or problem areas that may affect the processes of treatment and recovery.

<b>Fidelity</b>	Fidelity is the degree of adherence to essential elements in the implementation of an evidence-based practice. Programs with high-fidelity are expected to have greater effectiveness than low-fidelity programs in achieving desired client outcomes. Fidelity scales assess the essential elements of an EBP.
<b>Systems Integration</b>	The process by which individual systems or collaborating systems organize themselves to implement services integration to clients and families with COD as a routine practice that is supported by system infrastructure and is a core function of system design.
<b>Services Integration</b>	The participation of providers trained in both substance abuse and mental health services that develop a single treatment plan addressing both sets of conditions and the continuing formal interaction and cooperation of these providers in the ongoing reassessment and treatment of the client (CSAT 2005a). Services integration can be delivered through integrated programs or as integrated treatment. Different levels and types of integration are possible and there is no one way to achieve integrated treatment.
<b>Integrated Programs</b>	The collaboration of providers to create policies and procedures that address both sets of substance abuse and mental health needs in persons with COD.
<b>Consultation</b>	A relatively informal process for treating persons with COD, involving two or more service providers and requires the transmission of medical or clinical information or occasional exchange of information about the person's status and progress. The threshold for "consultation" relative to "minimal coordination" is the occurrence of any interaction between providers after the initial referral, including active steps by the referring party to ensure that the referred person enters the recommended treatment service.
<b>Collaboration</b>	A more formal process of sharing responsibility for treating a person with COD, involving regular and planned communication, sharing of progress reports, or memoranda of agreement. In a collaborative relationship, different disorders are treated by different providers yet the roles and responsibilities of the providers are clear. The threshold for "collaboration" relative to "consultation" is the existence of formal agreements and/or expectations for continuing contact between providers.
<b>Integration</b>	This activity in the continuum of programmatic responses requires the participation of providers trained in both substance abuse and mental health services to develop a single treatment plan addressing both sets of conditions and

	the continuing formal interaction and cooperation of these providers in the ongoing reassessment and treatment of the client. The threshold for “integration” relative to “collaboration” is the shared responsibility for the development and implementation of a treatment plan that addresses the COD.
<b>Integrated Treatment</b>	The skills and techniques used by providers to comprehensively address both mental health and substance abuse issues in persons with COD.

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